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Consent to medical treatment – does doctor know best?

A paper delivered to the Ulster Medical Society on 20th November 2003 by The Right Honourable Sir Robert Carswell, Lord Chief Justice of Northern Ireland *

One of the agreeable features about engaging in practice in the sphere of personal injuries litigation is the opportunity which it gives to lawyers to get to know a variety of medical practitioners. Over some 25 years I made a host of good friends in the medical profession, and I am glad to see so many here tonight, together with some legal stalwarts who are brave enough to put up with listening to me holding forth yet again. May I say what a pleasure it is to have the chance to address you and to renew old friendships.

The aspect of medical practice and its interface with the law which I want to discuss tonight is that of consent, the type of patient's consent which is required for medical and surgical procedures and the problems which can arise – and many of them have arisen in the past.

If one goes far enough back in time – and perhaps not beyond the professional lifetime of some of the audience tonight – consent did not pose much of a problem. You will of course remember that Hippocrates himself advised physicians to conceal most things from the patients, as when given information many patients have taken a turn for the worse. There is little doubt that there has historically been a paternalistic tinge to the practice of medicine, what one commentator called *"the oracular nature of early medicine, with heavy reliance on magical powers and ritual in preserving the mystique of the healer."* One also finds traces in some of the cases of the view, now perhaps regarded as old-fashioned, that patients prefer to put themselves in the hands of their doctors and are made more anxious by being given additional information. And think of the great surgeon Sir Lancelot Spratt in *Doctor in the House*: to the grandees of his day the idea that a patient might have a say in the operation to be carried out would have been outwith his contemplation. If the patient had had the temerity to pipe up and announce that he did not agree to it, Sir Lancelot (and many others of his time) would have regarded that as conclusive evidence of mental incapacity. And the mind boggles at the reaction he would have shown if the patient had attempted to sue him.

Modern legal and ethical requirements have made a big difference to the approach which doctors are obliged to adopt these days, and there is a discernible tendency to overload the information dumped on the patients about infinitesimal risks until the unhappy souls are either scared out of their wits or disregard the lot as incomprehensible mumbo-jumbo.

Consent as a concept is not a difficult thing, and any sensible person will ordinarily know quite easily when a patient consents to treatment. Lawyers love to break things down into components, however, and preferably to complicate them a bit, and so I can define for you three elements of a proper consent:

- capacity
- voluntariness
- sufficiency of information.

There is not really any magic in any of these. Obviously if a patient has not legal capacity, he or she cannot give consent. Equally obviously, if it is not voluntary no one could call it consent. The third part, information, overlaps to an extent with the second, because if you do not know what you are agreeing to, you can hardly give true consent. This part is a bit more difficult to apply in practice.

Perhaps I could say a word about each of these and how they affect the way that doctors have to go about their work and make their decisions. You will, I am sure, be aware that medico-legal text books contain a hefty chunk on the subject – 100 pages in Professor Michael Jones' tome on

* now Lord Carswell, Lord of Appeal in Ordinary, in the House of Lords.

medical negligence – and you could write a book on that topic alone, as London barrister Andrew Hockton has recently done. Indeed, a glance through the contents table of his book will show the breadth of issues on which the question of consent bears – children, incompetent adults, information and the duty of candour, negligence and causation. These concern such medical questions as sterilisation, abortion, blood transfusions, anorexia, euthanasia and termination of life, all against the background of the requirements of the law and the GMC guidelines on ethical practice.

One might start by asking what is the purpose of obtaining the patient's consent to a specified treatment. The answer is clear: it is a protection to the doctor against committing the actionable tort of battery. It has often been described as the key which unlocks the door, but Lord Donaldson MR in *Re W (a minor)* in 1992 preferred a different simile, a legal flak jacket, which protects doctors from litigious claims by giving them the right to proceed. That is the legal purpose of consent, but Lord Donaldson pointed out that the clinical purpose is of prime importance in medical practice, because a patient's confidence in the efficacy of treatment is a major factor contributing to the treatment's success.

But before they can don their flak jackets, doctors have to be clear on our three elements. So let us look for a moment at the first, the patient's capacity. It may seem obvious and superfluous to say that an adult of sound mind can and must make his or her own decision, but that statement conceals a number of serious practical problems. The American surgeon Arul Gawande in his book *Complications* tells a heartbreaking story of a patient in his early sixties with extensive and untreatable cancer who insisted on having spinal surgery which might prolong his life a little but which contained severe risks of serious damage and the certainty of a long, difficult and painful recovery. He was very thoroughly and meticulously warned of the risks and informed of the options – the overwhelming preference of the doctors was to do nothing and let him go home and receive hospice care, which gave him the best chance of dying peacefully. He insisted on proceeding and despite the best care – and the account given of the care devoted to him was impressive – the result was very unhappy indeed, described in harrowing detail by Dr Gawande, and he died in severe discomfort after fourteen days. Yet legally and, I think, ethically the doctors were right. He had to make the choice, and the ability to choose must imply the freedom to make the wrong choice. The patient's decision may appear irrational to any doctor or lawyer, but he is entitled to make it, even to the extent of refusing life-saving treatment or instructing the cessation of life-preserving treatment.

In her O'Connell Lecture in St Malachy's College last autumn Dame Elizabeth Butler-Sloss gave an example of the latter from her own experience. Ms B was an able and talented woman of 43, holding a responsible position in the NHS, who through a devastating illness had become tetraplegic and who no longer wished to be kept alive by artificial means. To begin with, her doctors took the view that she must be incompetent. They focused on the decision she had made, rather than on her actual state of mind, and decided that this decision could not be the product of a competent mind. However when the medical experts came to give evidence in court, it was universally agreed that Ms B was quite clearly mentally competent. It was clear that her right to choose to come off the ventilator without which she could not breathe had to be respected. Dame Elizabeth so decided and gave a declaration that the hospital must follow Ms B's instructions to withdraw her artificial ventilation. In so doing the judge hoped, though faintly, that Ms B might reconsider her decision, but she did not, and she died peacefully a short time later.

If the patient does not have proper mental capacity, no one can give consent on his or her behalf and it has to be obtained from the court (I leave out of account the exceptions, treatment under the mental health legislation for conditions affecting mental health and treatment in an emergency). There may be difficulties in practice in assessing mental capacity, but the rule is clear enough.

When we come to look at the position of minors, the difficulties fairly bristle. One might innocently suppose that because the age of majority is 18, a patient under that age cannot give or refuse consent to treatment. I regret to say that one would be severely disappointed, and the rules which have been built up are complex and to some extent baffling. Any experienced practitioner will know at once the areas in which the problems lie, the foremost being on the one side contraception and abortion, where the child will be anxious to have medical treatment and the parents may oppose it;

and on the other side anorexia, where the opposite may prevail.

The first inroad into the simple rule of consent at the age of 18 was made by section 4 of the Age of Majority Act (NI) 1969, by which a child aged 16 or more may give consent to medical treatment – though not the donation of organs or blood or other procedures which do not constitute treatment or diagnosis. The second was made by the courts in the litigation brought by the renowned Mrs Gillick. Mrs Gillick was one of the type of formidable ladies of strong moral fibre and strong moral views who form the backbone of all worthy bodies such as the Mothers' Union and the WI – though I could hardly imagine her posing as Miss November for the famous calendar. The DHSS issued a circular to area health authorities advising them that doctors consulted at family planning clinics could lawfully prescribe contraceptives to girls under 16, if acting in good faith to protect them against the harmful consequences of sexual intercourse. Mrs Gillick took exception to this in principle (I must add at once that it was a question of principle, as her own daughters were not seeking contraceptives). She sued the DHSS and the health authority and the case went right to the House of Lords, where she narrowly but decisively lost. The result is that a child under 16 who is what we now call *Gillick* competent may give valid consent to treatment on his or her own behalf, provided (and the proviso is important) that the treatment is in the child's best interests. The courts have said that what constitutes *Gillick* competence is a question of fact, which they usually say when they want to let someone else take the responsibility. It will depend on the age and level of understanding of the child and also on the complexity and importance of the treatment – consent to setting a fracture of the arm is not rocket science, whereas all doctors can think of difficult clinical decisions which a young person may not have the maturity or judgment to make unaided.

I cannot give you a set of hard and fast rules to govern the case of minors, but two guiding principles can be distilled from the voluminous case-law:

1. No doctor can be required to treat a child, either by the child, the parents or the court. It is a decision for the doctor's own professional judgment, subject to the threshold requirement of a valid consent.
2. There can be concurrent powers to consent. Either the child or the parents may be able to give valid consent, in which event only the failure or refusal by all will create a veto. The somewhat strange position is that the child can give consent under 18, but cannot refuse it, so the parent may give an overriding consent which will be valid if the child refuses (this may be important in anorexia cases).

The court can, however, give its consent and override a refusal which would block treatment, provided it is in the best interests of the child. There have been many carefully thought out statements of the law about the extent of the court's power and the occasions on which it should be exercised, but I need not trouble you with them tonight. All I need say is that sometimes the decision is not difficult to make, as I found in a recent case of a boy with vCJD (though there was no question of going against the family wishes in that case, they were very keen on the treatment). In other cases it may be fiendishly difficult, and you will remember how the Court of Appeal in England wrestled like Jacob with the angel when presented with the problem of the conjoined twins.

Once you have determined that the patient or some person on his behalf can give consent, the next question which arises is the amount of information which a doctor is required to furnish to him in order to make that consent valid. It is here that the law has some rather strange answers which I am not at all sure are very sound in principle. If you read the GMC or the Royal College of Surgeons guidelines on seeking consent you will find constant references to "informed consent", a concept which requires that the patient be given all the facts in a complete and comprehensible form, that all possibilities, including non-operative methods and non-treatment, are discussed, that a description of the expected outcome for each alternative procedure be given and that the patient should take part and share in decisions and give active, not passive, consent. This is not only excellent practical advice to doctors, but it constitutes the ethical requirement of their professional bodies, which of course they must observe. I think that it may represent the reaction of the profession to the conclusion reached in a 1986 study that doctors at that time regularly underestimated the amount that patients wanted to know.

Oddly enough perhaps, it does not represent the law. In our law it does not take very much information to ground a valid consent. Consent is consent, even if the patient only knows the outline of what the treatment is; so long as he is aware what he is agreeing to, his consent is valid in law. There is, however, a catch, as you might suppose. It is part of the comprehensive duty owed by the doctor to give the patient proper information about the proposed treatment, and in particular to warn of the risks which it may entail, and failure to do so to the standard of a reasonable practitioner will be actionable negligence. So obtaining the rugged consent required by English law is not enough: you must observe the professional standards of a reasonable medical practitioner practising in that field in order to discharge your legal duty.

Let me give you a couple of examples which have occurred in cases which I myself tried as a judge in the High Court:

1. A young woman was plagued with Raynaud's Disease, which caused blueness and swelling in her feet and ankles and severe pains in her legs. She was referred to a vascular surgeon, who after carrying out tests recommended that she should have a sympathectomy, done by the chemical method, involving the injection of a solution of phenol to burn the tissue of the sympathetic nerve. The object of the treatment was to destroy the lumbar sympathetic chain which supplies nervous control to the small blood vessels in the feet, and that should have removed the cause of the spasm and cured the affliction.

The injection was done by a consultant anaesthetist and it was accepted that it was done with proper professional skill and competence. Unhappily there occurred one of the known side-effects, the irritation of the genitofemoral nerve resulting in hyperaesthesia. Normally this lasts at most a few weeks, but in the case in question it persisted and undoubtedly caused the patient much distress and discomfort. The case turned on what she had been told about the risk and what it was good practice at the time to tell patients about it.

2. A patient was advised to have a hysterectomy carried out. She was particularly concerned about the location of the incision and the conspicuous nature of the resulting scar. She claimed that she was assured that it would be done by means of a Pfannenstiel's incision, leaving what the lady referred to throughout the case as a bikini-line scar. In the event the surgeon did not find it possible to make that type of incision and for good medical reasons made a mid-line vertical incision, which left a much more conspicuous scar. The patient became very distressed when she discovered the location of the operation scar and claimed that she had been given a guarantee that she would be left with a bikini-line scar. The surgeon for his part maintained that he could never have given such a guarantee, as the final decision on the incision could only be made on proper surgical grounds at the commencement of the operation.

Neither of these patients succeeded in her claim for negligence, because the doctors established on the facts that they had given proper information and warning in the circumstances of the case. But this sort of case is not going to go away, and my own view is that it may become more prevalent as people become more demanding and complaints-oriented, in medical matters as in everything else. How should doctors guard against it?

Let me return to the question of informed consent. That is a concept adopted in many other common law jurisdictions, notably in North America. It starts from the premise that medical treatment is a trespass or battery and that will be actionable unless proper consent is given by the patient, which is interpreted as informed consent. In order to obtain an informed consent the doctor must disclose all material risks. What are material risks? They are determined by the "prudent patient" test, formulated as follows in the leading American case of *Canterbury v Spence*, decided in 1972:

> "A risk is material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."

It is subject to the exception of the "therapeutic privilege", which enables a doctor to withhold information as to risk when a reasonable medical assessment would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient.

This standard is rather good advice to doctors who wish to know the extent of their ethical

obligation under the professional guidelines, though my personal advice would be to be extremely cautious about exercising the therapeutic privilege. But it does not represent our law, at least not at the present time. I insert this caveat because our law is moving into an era of rights-based doctrines, particularly since the Human Rights Act incorporated the European Convention on Human Rights into our law. And fairly recently Lord Irvine of Lairg in an article in the Medical Law Review suggested that the rights-based approach may encourage the courts to move away from the traditional doctrine towards that of informed consent. It does seem to me fairly likely that lawyers will cross-examine doctors about their observance of the guidelines, so be warned.

I referred a moment ago to the standard of care of a reasonable medical practitioner, but much as I might hesitate to burden you with complications, I fear that I have to do it, for we are getting into what is known as *Bolam* territory. I think that I had better go back to basics for a moment, and I hope that the lawyers will forgive me for stating what to them is obvious and elementary.

In general the standard of care which members of any profession are expected to reach in the exercise of the skills of their avocation is that of a reasonably competent member of that profession, the professional equivalent of that paragon of prudence, the man on the Clapham omnibus (I am afraid that this mythical character is a classic example of how the law clings to outdated institutions: the Clapham omnibus ceased to run in 1914).

If you are an architect or engineer, a landscape gardener or a marine hydrographer, that is the rule which will apply in unqualified form to the issue of your liability if your client has sustained damage and seeks to hold you liable. One will generally find that an expert in your field will give evidence on each side about the standard of care which a reasonable professional should adopt, and at the end of the day the judge has to decide whether that standard has been reached or whether you the defendant have fallen short of it. In the process he may have to weigh up the evidence of the experts if it conflicts and decide which should be preferred.

Not so for doctors. Their liability is governed by the well known *Bolam* test. Under that test if a doctor has followed a practice adopted by a responsible body of practitioners he or she is not to be regarded as having been negligent. In short, medical judgment rules, or doctor knows best. This is not the law in other spheres of activity. In the realm of industrial accidents it was thought for many years that following the established practice was a sufficient defence. But the employers' confidence in trade practice was rudely shattered when a case from this jurisdiction, *Cavanagh v Ulster Weaving Ltd* went to the House of Lords in 1959 and their Lordships held that trade practice is not conclusive. It may be strong evidence of lack of negligence if the defendant has followed it, but it is still open to the tribunal of fact to hold that that was not good enough.

One might have thought that medical negligence would be approached in the same way. But the issue was dealt with in 1957 by a puisne judge in the Queen's Bench Division charging a jury in *Bolam v Friern Hospital Management Committee* a case where the plaintiff had been undergoing ECT for treatment of a psychiatric disorder. In the course of this treatment he sustained dislocation of both hip joints, with fractures of the acetabulum and pelvis on each side. It was claimed that relaxant drugs should have been administered or manual control exercised, but it was proved that different views were held among competent doctors about the advisability of taking either step. The trial judge directed the jury in these terms:

> "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art."

He went on to say that it was not essential for the jury to decide which of two practices was the better practice, as long as they accepted that what the doctor did was in accordance with a practice accepted by responsible persons. You can see at once that this has got away from the general rule that the standard is that of reasonable care in all the circumstances, to be determined by the tribunal of fact.

The *Bolam* test has remained part of law for nearly 50 years now, though often criticised, and with some modification: in *Bolitho v City and Hackney Health Authority* in 1997 the House of Lords emphasised that to satisfy the requirement the body of medical opinion relied upon must be

not only responsible but respectable and reasonable. In order to qualify it must have a logical basis, formed by experts who have directed their minds to the question of comparative risks and benefits and reached a defensible conclusion on the matter. Once such a body of opinion has been proved to exist, however, that is a sufficient defence and the judge is not at liberty to pick and choose between the opinions expressed by medical experts, even though he might do that very thing in the next case involving the liability of a structural engineer.

One might have thought that even if it is justifiable on pragmatic grounds to judge the standard of actual treatment by this *Bolam* test, that should hardly apply to the issue of liability for failing to give a patient sufficient warning of adverse consequences of a proposed treatment, and one might have hoped that the courts would not apply the *Bolam* test in this area.

Unhappily for the law, at least in my own view, that was not to be, and the courts became distracted once again by the siren call of *Bolam.* In the case of *Sidaway v Bethlem Royal Hospital Governors*, decided in 1985, the House of Lords came down once again on the side of the application of the *Bolam* test and held that it should be applied in the sphere of warning of risks just as much as in diagnosis and treatment.

The patient, a woman of 63, had suffered from persistent pain in her neck and shoulders. She was advised by a neuro-surgeon, correctly as the court found, to have an operation on her neck to relieve pressure on a nerve root. The operation consisted of a laminectomy of C4 and a facetectomy or foraminectomy of the disc space between C4 and C5. The trial judge described the procedure as follows:

> "A laminectomy is an excision of the posterior arch of the vertebra. It gives the surgeon access to the foramen or channel through which nerves travel from the spine laterally... [The surgeon] freed the fourth cervical nerve root by removing the facets, or small bony protuberances, from the fourth vertebra and used a dental drill to free the nerve within the foramen."

It was found that the surgeon carried out the operation with proper skill and care, but sadly in its course some damage occurred to the spinal cord which caused a partial paraplegia. It was known that there was a risk of this occurring, the extent of which the medical witnesses placed at less than one per cent. The issue was whether sufficient warning had been given by the surgeon before the operation. The evidence was less than clear, because the surgeon had died before trial, but the judge held that it was probable that he did not refer specifically to the danger of cord damage when discussing the operation with her. There was, however, a responsible body of medical opinion which would not have given such a warning. The judge held that this concluded the matter, and the Court of Appeal and House of Lords upheld his decision. So once again the law has got away from the standard test of reasonable care, to be decided by the tribunal of fact.

The extension of the *Bolam* test to cases of warning has been strenuously criticised, I think with some justification. One can see a case for saying that it is extremely difficult for a layman to make a proper judgment about matter of diagnosis and treatment, and so in that sphere one should accept that if a body of responsible doctors would have taken the same course that should be a good enough defence. As I have said, I don't accept this, but one can at least see the force of the argument. But why should this be so when the issue is one of giving a sufficient warning, on which a layman can far more readily comprehend the issues and form a judgment? The courts have not allowed experts' opinion to be conclusive in other fields, so why should they do so in this one?

I think myself that it was a pity that the House of Lords did not see fit to adopt the regular method of determining the standard of care and take the opportunity to reject *Bolam* in this segment of medical negligence, which might have opened the way for jettisoning it altogether in some future case. But it was not to be, and one can only hope that it may reconsider the subject in time and reverse the rule. What are the prospects of this? Who knows? It might, but don't hold your breath waiting for it.

Let us suppose then that the doctor has failed to give the patient a sufficient warning and is to be regarded as having been negligent in that respect. What would the patient have done if a proper warning had been given? It would hardly accord with most people's sense of justice to hold the doctor liable for damages if that patient was set on having that treatment and would not have been put off in the slightest if the fullest warning of the

risks had been given. I am glad to be able to say that the law does not perpetrate such an injustice, but I am also sorry to say that it has got itself into some rather tortuous complications in trying to achieve a proper result. This part of the thicket is one for the lawyers to struggle through, rather than the doctors, who have done their best, or rather worst, and have to leave the unravelling to the other profession; but the difficulties involved may serve as a cautionary tale which will remind doctors of the need to stay alert to the need for warnings.

It is a necessary part of a plaintiff's proofs that the defendant's act or omission, in these cases the failure to warn of risks, caused the loss sustained, that is, the actual occurrence of one of the possible eventualities of which warning should have been given. Our law has always had problems with the concept of causation. One sees in the reported cases depressingly frequent references to causation being a matter of common sense, often described as "ordinary" common sense or "good" common sense. But one man's sense may be another man's nonsense, and whole books have been written on causation without producing any clear and workable tests. A celebrated article on the topic by the distinguished academic Sir Arthur Goodhart commenced with a passage to the following effect:

> "My grandson, aged three, fell over a chair. Being an intelligent child, he thereupon proceeded to kick the chair."

I fear that the discussion of the subject, certainly in decided cases, all too frequently fails to get above this level of philosophical subtlety.

Let me pose a couple of scenarios to you, taken from actual decisions, and ask you how you would have decided each case. The first is an Australian case, *Chappel v Hart*. The patient suffered from a pharyngeal pouch, a relentlessly progressive throat condition which required surgery. No matter how carefully or well the surgery was performed, it entailed a very slight risk of injury to the vocal cords which would leave the patient with a weak and gravelly voice. The doctor failed to warn her of the risk of damage to her vocal cords. She consented to the surgery and suffered damage to her cords. Understandably, then, she was very upset that the doctor had performed the operation with precisely the result she had feared.

It was not disputed that the doctor had performed the operation with reasonable care, but it was accepted that he was in breach of his duty to inform the patient. The difficulty in the case arose from a combination of several other of its features. First, she would sooner or later have needed an operation of the type he performed on her (although it was not essential at the time it was done), and she would have had the operation at some time even knowing of the risk of damage to her vocal cords. Secondly, the risk of what happened to her was inherent in that type of operation no matter who performed it, or when or how well it was performed. But, thirdly, if the doctor had performed his duty to inform the patient of the risk, she would have sought a second opinion and would have had the operation performed by the most skilled and experienced surgeon available. What do you think was the result? Did the patient win or lose? Well, after a long legal battle the High Court of Australia held by a majority that she could recover substantial damages.

The second case is an English decision, *Chester v Afshar*, decided in 2002. The patient was a journalist who had a history of miserable back pain. She saw a surgeon, who advised her that she needed three bulging discs removed and that in his hands the operation (microdiscectomy L3/4 and L4/5) would be straightforward; he gave her the impression that it was virtually risk-free. Unfortunately, things did not go as planned. The patient suffered both motor and sensory impairment, which was not cured by a second operation. The only explanation forthcoming was one of cauda equina contusion that may have occurred during the first operation. She sued for damages, alleging that the surgery was negligently performed. This part of the case did not succeed at trial. So she was back to the case based on failure to inform her of the risks. The relevant factors are hard to fit into a logical pattern:

1. The risk of nerve damage was very small, perhaps 1 to 2 per cent (though the surgeon himself estimated it at the remarkably precise figure of 0.9 %).
2. Nevertheless, if he had warned her, she would not have proceeded with surgery at that time.
3. As it was elective surgery and there was no need for speed, she would have postponed the surgery, but would probably have sought another opinion and had the procedure done at

a later stage.

4. Since the risk was so small, the odds were strongly in favour of her being less unfortunate the next time.

Should she win? Should she recover full substantial damages? The trial judge and the Court of Appeal held that she should.

This is very difficult territory, and I am rather reluctant to be critical of decisions which I should have found extremely difficult if faced with them myself. But I do wonder if a better approach might not have been via the concept of measuring a chance, which is used in other areas of tort law, and is very familiar to practitioners negotiating settlements. It would then not be a question of all duck or no dinner, but of what proportion of the full value of the damage sustained the plaintiff should recover. That has not found favour with our courts in this area of the law, or at least not yet. But some day perhaps it might . . .

Can I draw the threads of these rambling disquisitions together in order to see if there are any nostrums which I can offer to doctors – with, I may say, all the diffidence with which a practitioner in one discipline should feel when offering advice to experts in another:

1. I have no doubt that you have all made yourselves familiar with the ethical guidelines of the GMC and Royal College of Surgeons, for these are prime sources of guidance and instruction for members of your profession.
2. Obtaining consent is a more difficult matter in some cases than might have been thought in the past, and you might consider the wisdom of having it done at a suitably experienced level, not delegated to colleagues who are too junior.
3. Taking time to understand the concerns of the particular patient is important, and then to explain to that patient at a level of detail which he or she can understand what the treatment involves and where any material problems or risks may lie.
4. Above all, keep as good a note as you can. I know how difficult that must be when you are under pressure to deal with many things and time is at a premium – nor is it the most riveting task. But it can save you enormous worry and possible exposure to liability if you can prove months or years later, when ordinary recollection has naturally disappeared with time, what you said and what the patient agreed to.

One of the favourite hoary old stories of lawyers is of F. E. Smith, when he was a brash young man who frequently crossed swords with a particular county court judge. On one occasion that judge, after listening to an elaborate argument from F. E., remarked rather testily that he had listened to counsel's argument and was no wiser for it, to which F. E .replied silkily "No wiser, your Honour, but much better informed." I venture to doubt whether any of you present tonight are much wiser for listening to this paper, but I hope that you may be a little better informed and may be able to take something of benefit away from this evening.